APPENDIX 9
PRIOR AUTHORIZATION VISION SERVICES ATTACHMENT (PA/VA)

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/VA

PRIOR AUTHORIZATION VISION SERVICES ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

1	2	3	4	5
Recipient	Ima	A	1234567890	65
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAL ASSISTANCE ID NUMBER	AGE

PROVIDER INFORMATION

6	7	8
I.M. Provider, O.D.	88888888	(XXX) XXX . XXXX
REFERRING/PRESCRIBING PROVIDER'S NAME	REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	PERFORMING/DISPENSING PROVIDER'S TELEPHONE NUMBER

A. LENSES AND FRAMES

NOTE: Lens formula information is required for all requests for frames or lenses

LENS FORMULA: (L) +1.50-- ADD+2.75
(R) +1.50--

☐ REPLACEMENT ONLY

FRAME NAME: Far Horizon 94
FRAME MANUFACTURER: Martin-Copleland
☐ REPLACEMENT ONLY

☒ COMPLETE APPLIANCE (Lenses and frames)

B. SPECIAL LENS/FRAME REQUEST:

☐ Oversize
☐ Add over +.4.00
☐ Patient supplied frame
☒ Contract lab supplied frame
☐ Non-contract frame (Not supplied by recipient)

Justification for Non-Contract Frame:

(Principle justification may not be cosmetic; principle justification must be medically/visually necessity)

☐ Other (provide pertinent history /findings and justification along with specifics of request)

If request is for a non-contract item, estimate wholesale cost:

C. **TINTS:**

(All requests for tints must include specific documentation of visual or medical necessity from the prescribing provider. A diagnosis of photophobia, without substantiation is insufficient justification.)

☐ Rose 1 ☐ Rose 2 ☒ Photochromic

☐ Other tint (explain)

Justification for tint (See above)

Recipient has cortical cataracts which are causing excessive glare and light sensitivity. Photochromic lenses will help eliminate this glare and allow the recipient's visual system to function more effectively.

D. **OTHER VISION SERVICE REQUESTED:**

Service Requested:

Pertinent history/findings and justification:

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

E. MM/DD/YY
Date

J. M. Provider, O.D.
Requesting/Performing Provider's Signature